STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
	155095		B. WING		03/22/2012	
		_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R	2001 ⊦	IOBSON RD		
HERITA	GE PARK		FORT	WAYNE, IN 46805	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE	
F0000						
	This visit was for Complaints IN0 IN00105276.	or the Investigation of 00105054 and	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion act.	ot s	
				provider of any conclusion set forth in the statement of		
	Complaints IN0	0105054 and IN00105276		deficiencies, or of any violation	n of	
	_	Federal/state deficiencies		regulation.This provider		
		legations are cited at		respectfully requests that the		
	F157, F514.			2567L Plan of Correction be considered the Letter of Credi	hle	
	1107,1011.			Allegation.Based on past surv		
	Survey dates: N	March 14, 15, 16, 22, 2012		history and no harm identified		
	Burvey dates. It	viaicii 14, 13, 10, 22, 2012		any resident; this facility		
	Facility number	000038		respectfully requests a desk		
	Provider number			review in lieu of a post-survey revisit on or after April 6, 2012		
	AIM number: 1			Teviole of of after 7 pm 6, 2012		
	Alivi liuliloet.	10022/4830				
	Survey team:					
	Ann Armey RN	T, TC				
	Carol Miller RN					
	(March 16 and 2	22, 2012)				
	Shelly Vice RN					
	(March 15, 2012					
		,				
	Census bed type	2:				
	SNF: 22					
	SNF/NF: 144					
	Total: 166					
	10001. 100					
	Census payor ty	me.				
	Medicare: 22	P**				
	Medicaid: 101					
	Other: 43					
	Total: 166					
	10tal. 100					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. LDING	NSTRUCTION 00	(X3) DATE (COMPL		
		155095	A. BUI B. WIN			03/22/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE PARK				VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Sample: 7						
		es reflect state findings ace with 410 IAC 16.2.					
	Quality review 3 Williams, RN	/23/12 by Suzanne					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YWD711

Facility ID: 000038

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155095		A. BUILDING B. WING			COMPLETED 03/22/2012		
		1111	STREET ADDRESS, CITY, STATE, ZIP CODE				-
NAME OF P	ROVIDER OR SUPPLIER				OBSON RD		
HERITAG	GE PARK				VAYNE, IN 46805		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA						
	(INJURY/DECLIN	•					
	•	mediately inform the					
		with the resident's physician; tify the resident's legal					
		an interested family					
		ere is an accident involving					
		th results in injury and has					
		equiring physician					
	•	gnificant change in the					
		al, mental, or psychosocial					
	•	erioration in health, mental,					
		status in either life					
	threatening cond						
		need to alter treatment					
		a need to discontinue an reatment due to adverse					
	_	or to commence a new form					
	•	a decision to transfer or					
		sident from the facility as					
	specified in §483	•					
		also promptly notify the					
		nown, the resident's legal					
	•	interested family member					
		change in room or roommate pecified in §483.15(e)(2); or					
		dent rights under Federal or					
		lations as specified in					
	paragraph (b)(1)	•					
		record and periodically					
		ess and phone number of the					
		epresentative or interested					
	family member.		E014	_	E 457 NOTIFICATION OF		04/06/2012
		review and interview, the	F015) /	F-157 NOTIFICATION OF	hio	04/06/2012
	facility failed to	ensure the resident's			CHANGESIt is the practice of the provider to ensure the physicial		
	physician was no	tified timely in regard to			legal representative or an	,	
	an abnormal labo	oratory test which			interested family member are		
	indicated a need	-			notified when there is significant	nt	
			<u> </u>				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YWD711

Facility ID: 000038

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPLE	COMPLETED	
		155095	B. WIN			03/22/2	2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8			OBSON RD			
HERITAG	GE PARK				WAYNE, IN 46805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	· 	1	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE	
	This deficiency a	affected 1 of 7 residents			change in the resident's physic	cal,		
	reviewed for abr	normal laboratory tests in			mental, or psyhosocial status.			
	a sample of 7 (R	•			However; based on the allege			
		esident B).			deficient practice- the following	9		
	F: 1: : 1 1				has been implemented:What			
	Findings include);			corrective action(s) will be accomplished for those reside	nte		
					found to have been affected by			
	Resident B's reco	ord was reviewed on			the deficient practice:Resident			
	3/14/12 at 1:10 p	o.m., and indicated			B:The physcian was notified or			
	_	gnoses included, but were			the abnormal lab result and the			
	· `	npaired renal function			appropriate antibiotic was orde	ered		
	and urinary reter	•			and administered.How will you			
	and urmary reter	ition.			identify other residents having	the		
		1 1 10/5/40			potential to be affected by the			
		orders dated 3/7/12			same deficient practice and wi			
	indicated to obta	in a urine specimen for a			corrective action will be taken: other residents were found to	INO		
	urinalysis (U/A)	with a culture and			have been affected by the alle	ned		
	sensitivity (C/S)	if indicated.			deficient practice.Residents	gca		
					having abnormal lab value res	ults		
	The resident's nr	rogress notes dated 3/8/12			have the potential to be			
	_	cated a urine specimen			affected.The Nurse Managers			
	_				have been re-educated on			
	was sent to the la	aboratory.			obtaining lab results and ensu			
					the physician is notified timely			
		poratory test result dated			Education includes but is not limited to ordered labs being			
	3/10/12 at 06:31	(6:31 a.m.) indicated the			recorded on the Lab/X-Ray			
	resident had an u	urinary tract infection			Tracking Log upon receipt of the	he I		
	(UTI).				physicians order. The Tracking			
					Log is maintained by the Unit			
	The Physician's	Orders dated 3/12/12			Managers. The Unit Managers			
	1	er for Bactrim DS (an			check the log daily to ensure la	ab		
		*			results are received and the			
	antibiotic to treat UTI) one tablet twice a				physician is notified timely of abnormal values based on			
	day for / days fo	or a diagnosis of a UTI.			individual resident values. The	e		
	The Mediantian	Administration Record			Unit Managers check the lab fa			
					machine for lab results 2x/day			
	, ,	d the resident was started			and the Evening Nurse	tho		
	on Bactrim DS of	on 3/12/12.			Supervisor checks it 2x during	ине		

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Event ID: YWD711

Facility ID: 000038

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
		155095	B. WING 03/2			03/22/	2012	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R			OBSON RD			
HERITAG	GE PARK				VAYNE, IN 46805			
(X4) ID		STATEMENT OF DEFICIENCIES	1	ID	,		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
_				_	evening shift. The Weekend			
	On 3/16/12 at 7	:15 a.m., the Director of			Nursing Supervisor checks the)		
		· ·			lab fax machine for lab results	4x		
		e (DNS) was interviewed			during the Weekend Superviso			
		untimely physician			12 hour shift. Education provid			
	notification, and	the DNS indicated LPN			March 27, 2012 by the Directo			
	#3 should have	called the resident's			Nursing Services. The facility is			
	physician on 3/1	10/12 when the abnormal			contracting with a different lab scheduled to begin providing			
		results were received. The			service effective April 9, 2012.	The		
	•	the resident was not			Director of Nursing Services is			
					responsible to ensure			
		igns or symptoms of a			compliance.What measures w	ill		
	UTI.				be put into place or what syste			
					changes you will make to ensu	ıre		
	On 3/16/12 at 1	0:45 a.m., the DNS			that the deficient practice does	3		
	provided a late	entry on a Progress Note			not recur:Residents having			
	-	th indicated the resident's			abnormal lab value results hav	-		
	-	een aware of the resident's			the potential to be affected.The	е		
	1 2	(Vancomycin resistant			Nurse Managers have been re-educated on obtaining lab			
	1	` •			results and ensuring the			
		cterial infection) in the			physician is notified timely.			
		ed to make sure the			Education includes but is not			
	infection had re	solved.			limited to ordered labs being			
					recorded on the Lab/X-Ray			
	This federal tag	related to complaints			Tracking Log upon receipt of the			
	IN00105054 an	-			physicians order. The Tracking	9		
	11.00100001 un				Log is maintained by the Unit			
	2.1.5(-)(2)				Managers. The Unit Managers			
	3.1-5(a)(2)				check the log daily to ensure la results are received and the	aD		
					physician is notified timely of			
					abnormal values based on			
					individual resident values. The	Э		
					Unit Managers check the lab f	ax		
					machine for lab results 2x/day			
					and the Evening Nurse			
					Supervisor checks it 2x during	the		
					evening shift. The Weekend			
					Nursing Supervisor checks the			
					lab fax machine for lab results	4X		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155095		A. BUILDING B. WING	00	COMPLETED 03/22/2012	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	SE PARK			OBSON RD WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				during the Weekend Supervisor 12 hour shift. Education provide March 27, 2012 by the Director Nursing Services. The facility is contracting with a different lab scheduled to begin providing services April 9, 2012. The Director of Nursing Services is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice who trecur: A CQI monitoring too titled "Lab Monitoring" will be utilized every week x 4, month 3 and quarterly thereafter for 6-months. Data will be submitted to the CQI committee. If 95% threshold is not met; an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.	led r of s vill bl ly x ed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YWD711

Facility ID: 000038

If continuation sheet Page 6 of 9

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
	155095		B. WING 03/22/2012			2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			OBSON RD		
HERITAC	GE PARK				VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		//PLETE/ACCURATE/ACCE					
	SSIBLE	manimetric aliminal managers					
		maintain clinical records on accordance with accepted					
		ndards and practices that are					
		ately documented; readily					
		systematically organized.					
	,	, ,					
		rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
	State; and progre	reening conducted by the					
			F05	1.4	F514It is the practice of this		04/06/2012
		ation, interviews and	103	14	provider to maintain clinical		04/00/2012
	· ·	e facility failed to			recoreds on each resident in		
	document a med	ication as administered as			accordance with accepted		
	ordered on the M	Iedication Administration			professional standards and		
	Record. This de	ficiency affected 1 of 7			practices that are complete;		
	residents reviewe	ed for clinical records in			accurately documented; readily accessible; and systematically		
	a sample of 7 (Re	esident G).					
	w sumpre or / (re	osadin o).			organized. However; based of		
	Findings include				the alleged deficient practice-	uie	
	Tillulligs illetude	•			implemented:What corrective		
	.				action(s) will be accomplished	for	
		ord was reviewed on			those residetns found to have		
		a.m., and indicated			been affected by the deficient		
	Resident G's diag	gnoses included, but were			practice:Resident GThe cerovi		
	not limited to, de	epression and			liquid has been D/C'd related t		
	hypertension.				no longer being indicated.How you identify other residents	WIII	
					having the potential to be affect	cted	
	The Physician's (Order Sheet dated 3/1/12			by the same deficient practice		
	-	er dated 5/19/08 for			and what corrective action will	be	
					taken:No other residents were		
		used to treat or prevent			found to have been affected by	y	
		cy), give 5 milliliters (ml)			the alleged deficient practice		
	once a day.				Residents requiring medication	า	

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Event ID: YWD711

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155095	A. BUILDING B. WING 03/22/2012			2012	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			OBSON RD		
HERITAC	GF PARK				VAYNE, IN 46805		
		TATEMENT OF DEFICIENCIES	1	ID		1	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	REGGERTORT OR	resemble the first state of the		1710	be administered have the		DATE
	TTI N. 1.0010	36.15			potential to be affected by the		
	The March 2012				alleged deficient practice. The		
		Record (MAR) indicated			Licensed Staff have been		
	the medication c	erovite liquid, give 5 ml			re-educated on medication		
	once daily, was i	not signed out as given			administration documentation		
	from 3/1 through	n 3/16/12.			expectations. Education inclu		
					but is not limited to initialing of medications when administere		
	On 3/16/12 at 11	:45 a.m., LPN #1 was			reading the MAR when passin		
		egard to the cerovite			medications and reviewing	9	
		igned out as given, and			documentation at the end of th	neir	
		d she worked Monday			shift for completeness.A return	1	
		and had given the resident			demonstration for medication		
		· ·			administration/documentation		
		lication and not signed the			requirements has been completed with licensed		
		R. An observation with			staff.Education provided by the	٠ .	
	LPN #1 of the ce	erovite medication was			Director of Nursing Services a		
	available in the f	facility.			the SDC March 21-28, 2012.T		
					Unit Managers are responsible	e to	
	The Director of 1	Nursing Services (DNS)			ensure compliance.What		
	was interviewed	on 3/22/12 at 8:45 a.m.			measures will be put into place		
	in regard to the v	weekend doses of the			what systemic changes you wi make to ensure that the deficie		
	-	ed out as given. The			practice does not recur:Reside		
	_	he had spoken to the			requiring medication be		
		LPN #4, and the nurse			administered havae the pitenti	al	
	•				to be affected by the alleged	.	
	_	sident the cerovite			deficient practice. The License		
		not signed the March			Staff have been re-educated of medication administration	n	
		S further indicated			documentation expectations.		
		been prescribed the			Education includes but is not		
	cerovite due to h	aving a tube feed in the			limited to initialing off medicati	ons	
	past.				when administered, reading th		
					MAR when passing medication		
	This federal tag	relates to complaints			and reviewing documentation	at	
	IN00105054 and	•			the end of their shift for completeness.A return		
					demonstration for medication		
	3.1-50(a)(2)				administration/documentation		
	5.1-50(a)(2)		1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 03/22/2012			
	PROVIDER OR SUPPLIER GE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION			
				requirements has been completed with licensed staff.Education provided by Director of Nursing Services the SDC March 21-28, 2012 Unit Managers are responsi ensure compliance. How the corrective action(s) will be monitored to ensure the defi practice will not recur: A CQI monitoring tool titled "Medica Administration Documentation will be utilized every week x monthly x 3 and quarterly thereafter for 6 months. Data be submitted to the CQI Committee. If 95% threshold not met; an action plan will be developed. Non-compliance facillity procedure may result disciplinary action up to and including termination.	s and the ble to ticient ation on" 4, the will this be with thin			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YWD711

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